STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005007	A. BUILDING _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOWARD REGIONAL HEALTH SYSTEM	3500 S LAFOUNTAIN ST KOKOMO, IN 46904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 1 (one) State hospital complaint investigation. Complaint: #IN00096774 Unsubstantiated; lack of sufficient evidence. Facility: #005007 Date: 4-19-2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Howard Regional Health System is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Indiana State Hospital Licensure Rules. QA: claughlin 05/16/12	S 000		